MAXIMUS Federal Services

Case Number:	CM13-0071009		
Date Assigned:	02/07/2014	Date of Injury:	05/22/2012
Decision Date:	07/11/2014	UR Denial Date:	12/07/2013
Priority:	Standard	Application Received:	12/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 50-year-old male who has submitted a claim for Cervical Spine Sprain/Strain, Lumbar Spine Sprain/Strain, Myospasm, Gastritis, Upper Extremity Neuropathy, and Lower Extremity Radiculopathy and Neuropathy, associated with an industrial injury date of May 23, 2013.Medical records from 2013 were reviewed, which showed that the patient complained of constant mild to moderate upper back pain with persistent radiation, numbness, and tingling sensation going down his left arm. He also complained of constant moderate to severe low back pain radiating to the hips with numbness and tingling down his legs. The patient also noted that he had less insomnia. On physical examination, there was tenderness and spasm of the cervical paraspinals and the suboccipital area. The range of motion was limited secondary to pain. The compression, Spurling, and Distraction tests were negative. The reflexes were intact, but there was diminished sensation of the right upper arm. An examination of the thoracolumbar spine revealed tenderness and spasm of the paraspinals and bilateral sacroiliacs. The range of motion was limited secondary to pain. The sitting root test was negative, and the straight leg raise test was negative. Reflexes and sensation were intact.The treatment to date has included medications, physical therapy, acupuncture, and chiropractic care.Utilization review from December 17, 2013 denied the request for twelve (12) supervised functional restoration program (FRP) for the neck and low back, because there were no objective measures presented and there was no description of the components of such a program.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

TWELVE (12) SUPERVISED FUNCTIONAL RESTORATION PROGRAM (FRP) SESSIONS FOR THE NECK AND LOW BACK: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (Functional Restoration Programs) Page(s): 30-32.

Decision rationale: The Chronic Pain Guidelines indicate that functional restoration program participation may be considered medically necessary when all of the following criteria are met: (1) an adequate and thorough evaluation including baseline functional testing was made; (2) previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) there is significant loss of ability to function independently; (4) the patient is not a candidate where surgery or other treatments would clearly be warranted; (5) the patient exhibits motivation to change; and (6) negative predictors of success have been addressed. In this case, the medical records did not provide an adequate evaluation and there was no discussion regarding failure of previous treatment. There was also no discussion regarding absence of other options likely to result in improvement. Furthermore, there was no evidence that the patient lost his ability to function independently and negative predictors were not addressed. The criteria were not met. Therefore, the request for is not medically necessary.